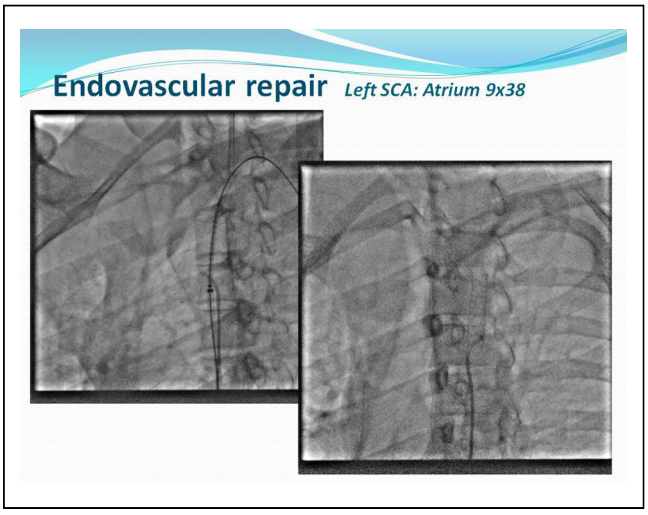

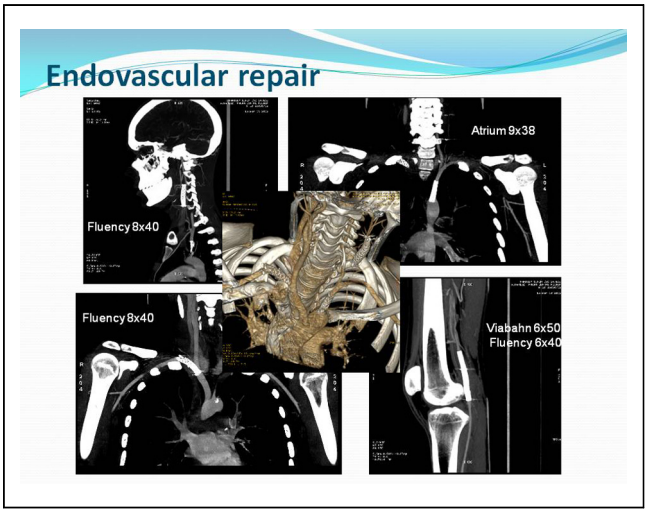

Case Summary. Discussion: We report a case of 18 year-old male with Hepatitis C virus (HCV) infection who presented with large aneurysms involving left common carotid artery (CCA), right and left subclavian arteries (SCA) and left popliteal artery. On evaluation he was found to have cryoglobulinemia(CG). Successful endovascular repair was undertaken with covered graft stenting to all the above said vessels. This report is unique as it describes large vessel involvement in CG which is not reported previously and highlights the feasibility of safe multiple pseudoaneurysm stenting.

TCTAP C-162

Recurrent Occlusion After Left Iliac Vein Stenting in a Patient with May-Thurner Syndrome

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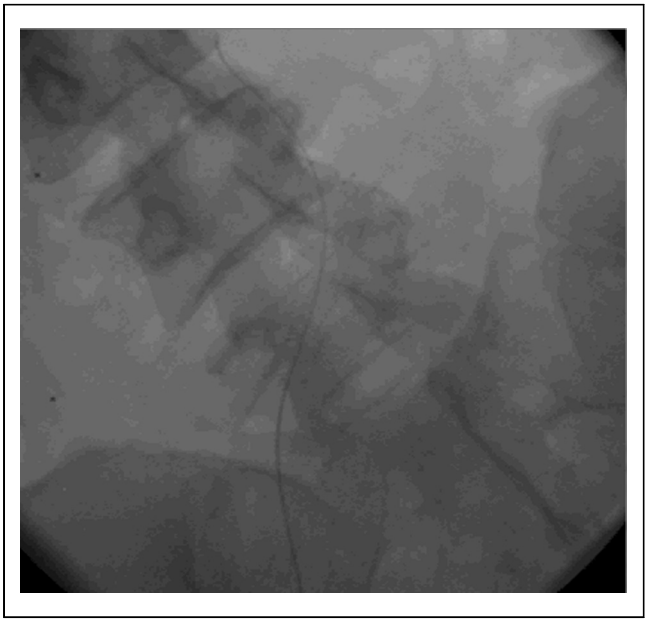
[CLINICAL INFORMATION]

Patient initials or identifier number. CJH

Relevant clinical history and physical exam. A woman of forty three year old was transferred to our ER due to left leg pain and swelling for 5 days. The patient was diagnosed with May-Thurner syndrome by CT-venography at the other hospital. The left leg swelled and congested from thigh to foot.

[INTERVENTIONAL MANAGEMENT]

Procedural step. Next day, we planned to perform manual catheter thrombectomy and stent implantaion. We placed a IVC filter via the right groin. Then we turned patient to the prone position and inserted a 8-Fr sheath into the left popliteal vein. Venography revealed that thrombus filling in the deep femoral vein did not allow seeing the iliac vein (video 1). Soft 0.035'' guidewire and 8F catheter were used to navigate through the occlusion and to aspirate the thrombi. After aspirating the thrombi, we passed the guidewire to IVC through the compressed left iliac vein. Then we widened the stenotic vein with a balloon of 4*40 mm and implanted a self-expandable stent of 14*60 mm. We used intravenous heparin infusion via the popliteal sheath overnight. Next day, the left leg swelled again. Follow up venography showed completely occluded external iliac vein and stenting site of common iliac vein with thrombi. Also we found the stent was shortened and the distal part of it folded inward. We thought the suction catheter pushed the distal end of stent during the additional suction of thrombi after stenting (video 2). We used catheter-directed thrombolysis with tPA concurrently with heparin for 48 hours. Then we implanted a Wall stent of 16*60 mm into the folded stent (video 3). She took anticoagulation with iv heparin with transition to warfarin before discharge. The IVC filter was retrieved. Ten-month follow up CT-venography revealed the stent was patent and no thrombus in the vein.



Case Summary. In this case, stent folding was caused by pushing of the manual aspirational catheter at the distal end of the stent. The folded portion of stent can be a trigger to form thrombus. So an aspiration catheter should be carefully manipulated after stent implantation. Additional stent insertion in severe incomplete stent apposition of self-expandable stent is a good rescue method to make the lumen patent.

TCTAP C-163

Rare Infectious Aneurysms of Right SFA Which Was Expanded to Avoid a Stent

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[1]Shin-Koga Hospital, Japan

[CLINICAL INFORMATION]

Patient initials or identifier number. 08629201

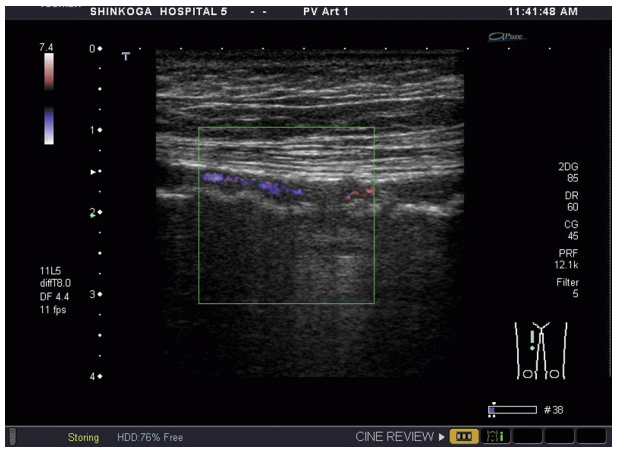
Relevant clinical history and physical exam. A 50-year-old man previously treated for leg claudication was admitted to hospital for in stent restenosis.

He had been stented to right SFA in July, 2010, and, had many risk factors dyslipidemia, current smoking, hypertension, diabetes mellitus, chronic kidney disease, and hemodialysis.

Relevant test results prior to catheterization. The ABI decrease at both side, right side 0.25 and left side 0.41.

Lower limbs artery echo could not check enough by hard calcification,but slightly blood stream was confirmed, and it was mean that right SFA is not occluded.

CT angiography showed right SFA severe stenosis and tandem lesion, and left side too.



Relevant catheterization findings. He was treated twice, because of right SFA stent was occluded after first session.

On July 25, 2014, we performed first session.

A six French guiding-catheter was engaged at the left femoral artery.

Baseline angiography via the left femoral artery showed a severe stenosis at the same as that seen on CT.

We performed stent after POBA for right SFA lesion.

But, only 8days after this lesion was occluded.

Therefore, we performed second session, expanded the stent by balloon catheter again.